STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150166	A. BUILDING 01 B. WING	11/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HOSPITAL	9301 CONNECTICUT DR CROWN POINT, IN46307

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K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 11/01/11 Facility Number: 006619 Provider Number: 150166 AIM Number: NA Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Pinnacle Hospital was found not in compliance with Requirements for Participation in Medicare, 42 CFR 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type ll (111) construction and fully sprinklered. The facility has a fire alarm system with system based smoke alarms	K0000	On October 25, 2011 Pinnacle Hospital (“Pinnacle”) has entered into a contract with RITEWay Services, Inc. for annual onsite training and surveys to ensure Life Safety Code compliance. The contract is attached as Exhibit 1. By entering into this contract, Pinnacle has committed to make best efforts to comply with all standards of the Life Safety Code.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	in corridors and hazardous areas. The facility has the capacity for 18 patients and had a census of 5 patients. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0046	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on record review and interview, the facility failed to provide documentation of 30 second testing at 30 day intervals and annual testing for 1 1/2 hours for 32 of 32 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice	K0046	Starting November 30, 2011, and continuing on the last Wednesday of every month, the Materials and Facilities Operations Manager will oversee the 30 second testing for 10 of 10 battery powered emergency lighting fixtures at Pinnacle. The Materials and Facilities Operations Manager will oversee the conduction of an annual 1.5hours testing for 10 of 10 battery powered emergency lighting fixtures at Pinnacle. The testing will be logged on the Pinnacle Hospital Call Emergency Light Testing Report which is attached as Exhibit 2. Please note there are 10 battery powered emergency lighting fixtures located in the hospital, rather than the 32 indicated in the survey. The 32 number included the Exit	11/30/2011

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	could affect patients in the surgery and recovery areas, and visitors and staff in service and exam areas throughout the facility. Findings include: Based on review of facility fire safety inspection and test records with the director of materials management on 11/01/11 at 12:35 p.m., there was no record of 30 second monthly and 1 1/2 hour annual tests for the 32 battery powered emergency lighting fixtures located throughout the hospital. The director of materials management said at the time of record review, the testing had not been done.		sign lights which will also be tested. The Materials and Facilities Operations Manager will additionally review on a monthly basis the logs, to ensure compliance with this standard.	
K0048	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include the evacuation of the smoke compartment in the written	K0048	On November 18, 2011 the Code Red Fire Policy No. S5 was revised to include evacuation from one smoke compartment to another	11/18/2011

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	fire plan for the protection of 5 of 5 inpatients in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the Hospital Wide Code Red-Fire Safety Plan on 11/01/11 at 12:55 p.m. with the director of materials management, the plan referred to the rescue of persons in immediate danger. The plan addressed evacuation from the building but there was no reference to evacuation from one smoke compartment to another smoke compartment. The plan		compartment,containment of fire procedures, the fire extinguishers which are available and the materials which the extinguisher can be used on. The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard and will review the sign-in sheet after each drill to ensure compliance. The revised policy is attached as Exhibit3.	

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	addressed containment of a fire only by covering the actual fire rather than separation by closing doors to the fire site. Extinguishment was addressed for "approved fire extinguishers" but nothing addressed what fire extinguishers were available and what materials the fire extinguisher was approved for. The director of materials management acknowledged at the time of record review, the fire plan failed to address all issues.			
K0050	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 1. Based on record review and interview, the facility failed to ensure fire drills were conducted	K0050	Pinnacle Hospital currently conducts a fire drill, at unexpected times, on a quarterly basis during each of the three	11/18/2011

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	on every shift during 2 of the past 4 quarters. This deficient practice affects all occupants of the facility including staff, visitors, and residents. Findings include: Based on a review of Fire Drills provided for the past year with the director of materials management on 11/01/11 at 11:55 a.m., fire drill documentation was not found for the second and third shifts of the fourth quarter in 2010 and the first and third shifts for the third quarter in 2011. The director of materials management said at the time of record review, the drills had not been done. 2. Based on record review and interview, the facility failed to ensure fire drill documentation included all staff participating for all shifts during 4 of the past 4 quarters. LSC 4.7.2 requires drills include suitable procedures to ensure all persons subject to the drill participate. This deficient practice affects all occupants of the facility.		shifts. However, the Materials and Facilities Operations Manager has revised the fire drill schedule so that the time of the drill of each particular shift will vary by at least 2 hours each quarter. For example: for the 1st Quarter, Pinnacle may have a drill at 7am for Shift 1, but during the 2nd Quarter, the drill will not occur before 9am. The log for the fire drills is attached under Exhibit 4. Also, a Fire Drill Observer Evaluation Checklist which includes a sign-in sheet for participants and is attached under Exhibit 4. Each participant will include details of their participating on the sign-in sheet. The first drill for this quarter will be conducted during the last week of November. The Materials and Facilities Operations Manager will review on a monthly basis the logs, to ensure compliance with this standard. The Materials and Facilities Operations Manager has trained each Department's manager to ensure that fire drill participants sign the sign-in sheet. The Materials and Facilities Operations Manager will also review the fire drill sign in sheets on a monthly basis at the Safety Meeting to ensure that all appropriate staff are participating in the drills.	

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	Findings include: Based on a review of Fire Drills provided for the past year with the director of materials management on 11/01/11 at 11:55 a.m., the fire drill documentation for the past year listed less than the number of staff on duty for each drill document. The director of materials management acknowledged at the time of record review, not all staff had signed the fire drill participation record. Signatures were collected for those in the area of the immediate "fire" site as other staff were busy caring for patients.			
K0062	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure a weekly test to check water flow conditions for 2 of 2 fire pumps was conducted as required by NFPA 25, the Standard for the Inspection, Testing and	K0062	The Materials and Facilities Operations Manager has already corrected this deficiency. On 10/26/2011, she was trained to conduct a weekly Fire Pump test to check water flow conditions for the fire pumps. Since this training she has performed a test every	11/18/2011

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	Maintenance of Water-Based Fire Protection Systems 5-3.2.1. This deficient practice could affect all occupants. Findings include: Based on review of maintenance records on 11/01/11 at 12:15 p.m., checks of the fire pumps were documented on Sprinkler Inspection Reports dated 12/15/10, 03/09/11, 05/21/11, and 08/03/11 by the facility sprinkler inspection contractor. No record of a weekly test of the fire pumps was found. The director of materials management said at the time of record review, no other testing had been done, she had "just learned this week" how to perform the weekly test, and a test protocol was to begin next week.		Wednesday on10/26/2011, 11/2/2011, 11/9/2011, and 11/16/2011. A Fire Pump Test log was created to record that pumps operate in accordance with the Life Safety Code Standard. The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard, and shall review all logs on a monthly basis at the Safety Meeting to ensure that testing is being completed in a timely manner. The Fire Pump Test logs for the tests performed are attached as Exhibit 5.	
K0069	Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 range hood's fire	K0069	It is Pinnacle's practice to ensure the automatic range hood extinguishing system are inspected for fire safety every six (6) months. On 10/5/11, after a	11/18/2011

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	extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the kitchen where 4 staff were observed. Findings include: Based on a review of fire safety inspection records for the automatic range hood		life safety code review by RITEWay Services, Inc., it was identified that the hood had a missing inspection. The Materials and Facilities Operations Manager immediately scheduled an inspection which occurred on 10/5/11. To prevent a missed inspection from occurring in the future, the Materials and Facilities Operations Manager has trained the Dietary Manager to ensure that inspections are scheduled and performed on a timely basis. Further, on a semi-annual basis at the Safety Meeting the Materials and Facilities Operations Manager will review with the Dietary Manager to ensure that the inspection has been completed.	

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	extinguishing system with the director of materials management on 11/01/11 at 1:30 p.m., the most recent inspection and service record for the commercial range hood fire equipment system was dated 10/05/11. No documentation for an inspection for the previous six month inspection was found. The director of materials management said at the time of record review, the previous test had not been done.			
K0144	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems for the east/west wing. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in	K0144	Generators are inspected and tested automatically on a weekly basis at Pinnacle, however the documentation of these test were deficient. On November 18,2011, the Materials and Facilities Operations Manager created an Emergency Generator Weekly Inspection/Run Log and an Emergency Generator Monthly Load Test Log which will document the results of all generator tests. Moreover, there is a Criteria checklist that the	11/18/2011

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	accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants of the east/west wing. Findings include: Based on review of the Generator Weekly Log Sheet with the director of materials management on 11/01/11 at 12:45 p.m., the generator load test was included on the weekly test record, but there was no information recorded for the actual test time a monthly load was conducted, operating temperatures or other information		inspector will go through in conducting these tests. These logs and checklist are attached under Exhibit 6. The next weekly check will occur on November 22, 2011. The next monthly inspection will occur December 2, 2011, the first Friday on every month. The Materials and Facilities Operations Manager is charged with ensuring that the Hospital is in compliance with this standard, and shall review all logs on a monthly basis to ensure that testing is being completed in a timely manner.	

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	to indicate the generator was tested under load, and nothing to indicate the percent load carried when the generator was load tested. No load bank information was provided. The director of materials management said at the time of record review, she did not know the percent load carried on the generator during testing and everything was done "automatically", including a load test at 6:00 a.m. the first Friday of each month. No actual transfer time was ever documented.			